STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 01 B. WING	08/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER	14751 CAREY RD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/10/12 Facility Number: 012548 Provider Number: 155790 AIM Number: 201023760 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Kindred Transitional Care and Rehab-Bridgewater was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 120 and had a census of 90 at the time of this visit. The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility services including the generator transfer switch and medical gas storage which was not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/13/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 Based on observation and interview, the facility failed to ensure 10 of 11 exit door electromagnetic locks remained unlocked while the fire alarm was activated. LSC 18.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6(a) requires doors with special locking arrangements such as electromagnetic locks to unlock upon actuation of an approved fire alarm system installed in accordance with LSC 9.6. This deficient practice affects all 90 residents, staff and visitors needing to exit the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 3:00 p.m. on 08/10/12, the electromagnetic locks on all facility exits, except for the main entrance, did not release and remain unlocked when the fire alarm was activated at 2:19 p.m. Based on interview at the time of the observations, the Maintenance Director stated the main entrance is locked overnight and acknowledged the electromagnetic locks	K0038	This serves as the Allegation of Compliance for Kindred Transitional Care & Rehabilitation-Bridgewater for the recent complaint survey dated 8/10/2012. Kindred-Bridgewater asserts that all corrections described on this Plan of Correction have been implemented. In regards to the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of action. The staff of Kindred-Bridgewater is committed to delivering high quality health care to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit Kindred-Bridgewater is in substantial compliance as set forth below, we are confident that it will be found in substantial compliance with regulations upon re-survey. The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. The facility provides exit access arranged so that exits are readily	08/27/2012

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	on all facility exits, except for the main entrance, did not release and remain unlocked when the fire alarm was activated. 3.1-19(b)		accessible at all times in accordance with section 7.1. 1. The exit door electromagnetic locks release when the fire alarm is activated. 2. The facility only has the one fire alarm system and is maintained by the Maintenance Director and by an outside vendor through quarterly checks. An outside vendor replaced the faulty relay module that caused the malfunction of the exit door locks 3. An LED on the power supply box that supplies power to the relay module lights red when it is functioning properly. A backup relay is onsite in case of future failure. 4. Monitoring by the Maintenance Director or designee will occur weekly during Life Safety rounds and be reported through the Safety committee to the Performance Improvement committee. 5. Completion date will be 8/27/12.	